

EAST LOUISVILLE DERMATOLOGY P.S.C.

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient Understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

Consent for release of information to specific others:

Please list specific persons below and their relationship to the patient that you authorize East Louisville Dermatology, P.S.C. to release information to, by means of verbal communication (in person or by phone), fax, mail, or paper copy regarding your medical care and treatment. Please mark None if this does not apply.

None

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

I give consent for the practice to leave a voicemail with personal health information including, but not limited to pathology results, laboratory results, information regarding prescriptions, etc. on the phone number listed here _____ or I do not give my consent to leave personal information on any voicemail.

Signature: _____ Date: _____

This Consent was signed by (please print): _____

Relationship to patient (if other than patient): _____

For office Use Only

Consent received and witnessed by _____ on Date _____

Consent refused by patient, and treatment refused as permitted.